BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

ABORTION

WILLIAM H. GILBERT, M. D. (746 Francisco Street, Los Angeles).—There is a wide difference of opinion as to the best method of treating abortion. Much of this is due to the fact that misunderstandings arise as to which phase of the condition is under discussion. Very often under the general head of abortion follow discussions of hemorrhage and sepsis, with no distinctions made between the different methods of treating each condition. As a rule, hemorrhage occurs early, while sepsis is a complication of a later date, and presents an entirely new aspect of the case. It has been said that hemorrhage is the only reason for operative interference and that all other abortions would clear up spontaneously if let alone. This is contrary to my experience and I believe it to be erroneous. After having tried the non-interference plan of treatment I have become convinced that it is followed by a much higher percentage of infections. This must not be construed, however, as a plea for operative interference in all stages of abortion. Meddlesome surgery is as dangerous in the early stages of gestation as when the fetus has gone to full term. The man who curettes all of his patients, irrespective of the state in which he finds them, will have a high mortality rate due to puerperal sepsis. Personally I am of the opinion that the two extremes, curettage of all patients, or curettage of none, have no place in the treatment of abortion. I believe, though, that the dead products of conception are better out of the human body if they can be removed safely. However, forceful and violent cervical dilatation, made with either the finger or instrument; vigorous and rough use of the sharp curette; packing the uterus very tightly with large quantities of gauze, in any stage of an abortion: these are types of operative interference which are almost sure to be followed by complications.

While it is surprising how much trauma and laceration nature will stand when due to normal delivery, she resents most emphatically a much less degree of roughness at the hands of man; and without doubt the disrepute that has attached itself to operative interference has resulted from the manner in which the early pregnant uterus has too frequently been handled.

For the sake of convenience let us classify abortion as septic and nonseptic. Quite a number of factors enter into the treatment of either type. Complications often make treatment extremely difficult. For instance, to empty safely an adherent, retroverted uterus with an undilated cervical canal, is sometimes a difficult procedure. A woman with diseased tubes and adhesions should be handled with the greatest care, as a disastrous or fatal peritonitis might result from undue manipulation of the uterus. In several instances in my own practice, the presence of fibroids in the muscular structure of the uterus has seriously interfered with the removal of the dead products of conception. Sometimes the uterus contracts in the middle, producing an hour-glass contraction, with the fetus, placenta, etc., implanted in the upper segment. These are conditions that should be given serious consideration, and to overlook any of them is to invite disaster.

Abortion when not complicated by interference—in other words, spontaneous abortion—is many times completed by nature, and unless the products of conception are not delivered, is rarely complicated by sepsis. The criminally induced abortion always carries with it the serious danger of sepsis, resulting from instrumental contusion and contamination of the cavity of the uterus or from the products of conception themselves.

Hemorrhage is always an indication for operative interference and should not be delayed too long, as exsanguination results in diminished resistance to infection. Many times the cervical canal is widely dilated and the fetus with the placenta and secundines lie adjacent to the inner portal of the uterine cavity, and their removal is a comparatively simple matter. Other times an injection of pituitrin is all that is necessary. If instrumentation is resorted to, it is always advisable under these conditions to forego the sharp curette and use either a blunt-nose sponge forceps or the gloved finger. I know of no agent more capable of cleaning the cavity of the uterus with so little harm as the gloved finger. Forcing its entrance into the cavity should never be done.

Because the gloved finger is the best curette under certain conditions does not mean that one is justified in trying to force a blunt, stub-nosed index finger through an insufficiently dilated cervical canal. The sad picture of an individual, with one hand behind the pubes while an assistant holds a volsellum which repeatedly pulls out of the cervix, trying to force the index finger into the cavity of the uterus, is not an uncommon one. Volumes have been written about the wonderful work that can be done with the finger as a curette, to all of which, under certain conditions, I agree, with the stipulation that there be sufficient dilatation of the cervical canal; and if sepsis exists, that there be no involvement of the appendages and parametrium. I am satisfied that the sharp curette has no place in our armamentarium. It can do nothing that cannot be accomplished with the dull curette and the blunt forceps. With either of these instruments, used cautiously, very little harm can be

done. The human being does not exist who can wield a sharp curette inside the cavity of the uterus and know whether or not he is damaging its walls or cutting through that oftentimes thinned-out structure. I am satisfied that more harm than good has resulted from its use.

Rapid and forceful dilatation of the cervical canal is a dangerous procedure; this is especially true if the Godell type of instrument be used. Once its curved expanding jaws open within the uterine cavity, no man can tell exactly what will happen. Numerous instances of ruptured uteri have been reported. As a consequence a previously uninfected abortion is converted into a condition which may require a hysterectomy in order to save a life. If the Godell dilator is used, great caution must be exercised in opening its jaws. It is far better to dilate slowly and carefully with graduated sounds of the Hegar type.

With the emptying of the uterine cavity comes the question of intra-uterine irrigation and packing. Without doubt many cases of infected tubes and peritonitis result from following either of these procedures. I believe the sharp curette and the intra-uterine irrigating nozzle should be relegated to oblivion. Their very existence in one's tool kit is a menace. Packing the uterine cavity under certain conditions is a very useful procedure. As a means of controlling hemorrhage it has no superior. It should never be too tightly done, and in order to be accomplished successfully there must be sufficient enlargement of the cervical canal. The uterine walls can be easily punctured by a dressing forceps carrying a strip of gauze. I believe that uterine irrigation and tight packing are common causes of endometrial implants in the abdominal cavity.

The treatment of infected abortions depends upon the stage of the infection. Operative interference is justifiable early in its existence. Once the uterus is infected, greater care must be exercised than at any other time. Nature becomes very busy at this time, erecting a local and constitutional defense wall against the infection. It is of the greatest importance that the local defense line be not disturbed or broken up. If the infection and inflammation can be confined to the uterine body, the chances for recovery are greatly enhanced, and the prospect of damage to the other organs is lessened. Once the infection has spread into the parametrium and the ovaries and tubes, with resultant localized peritonitis, it is extremely dangerous for one to attempt operative interference within the cavity of the uterus. By this time sapremia and more or less septicemia exist, and the treatment should consist of aiding nature in the fight against the infection. If ever there is a time to proceed cautiously, it is now. Watchful waiting, with application of an ice bag, rest in bed in the Fowler position, relief of pain, and proper feeding, will many times carry the patient through the stormy period. When the infection spreads into the parametrium, abscesses both within and adjacent to the tubes often form. Once a diagnosis of this condition is made, a posterior colpotomy is justifiable; care being taken, however, not to break through the layer of plastic lymph nature has thrown over the inflamed area. If this is disturbed or broken through, general peritonitis may result. There is often persistent vomiting. This is generally relieved by gastric lavage and use of the Connell apparatus for duodenal drainage. I am satisfied that this agent is a wonderful factor in affording comfort and saving lives of these patients. Outside of morphin for relieving pain, medical treatment is of little avail. Constipation generally exists, but cathartics are never advisable. A loop of ilium can be brought through the abdominal wall, and drainage instituted for the relief of obstruction and tympanites. This, however, is rarely necessary if the Connell apparatus is used immediately on the onset of vomiting. Its introduction should never be delayed; its early use may save the patient's life. Intravenous injections of mercurochrome have not been successful in my hands. Blood transfusions and intravenous injections of normal saline and glucose are of great value. Operative interference through the abdomen is rarely successful if attempted during the acute stage of the disease. As a rule infections of this kind run a limited course. Once the blaze has subsided, operative procedure may be indicated and justified.

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JOHN W. SHERRICK, M. D. (350 Twenty-Ninth Street, Oakland).—In the treatment of abortion there are involved certain general principles which apply to practically all cases, but it is most important to individualize and to bear in mind the particular type of abortion and any complicating features with which we are dealing. We are concerned in this discussion, then, with six types of abortion, namely, habitual, retained, threatened, inevitable, incomplete, and infected abortion.

The keynote of the treatment of any type of abortion is intelligent conservatism characterized by bed rest, sedatives, and general supportive measures. This precludes the use of enemas, drastic cathartics, and rough abdominal or pelvic examinations. However, many of these patients sooner or later should be subjected to a gentle vaginal inspection under strictly aseptic precautions. Interference is instituted as demanded by the particular details of a given case and its complicating features.

Habitual abortion presents often a most perplexing problem and should be treated primarily by prophylaxis. This implies exhaustive study and treatment of the patient and her husband for such complications as syphilis, chronic infections, general debilitating diseases, anemia, endocrine and metabolic dysfunction, local pelvic pathology, toxic factors of various types. It is particularly important to abstain from coitus in the early months until the uterus is well out of the pelvis, and in some cases it is better avoided during the entire pregnancy.

Retained abortion presents no particular problem. The condition should be dealt with in only one way, namely, gentle but thorough curettage,

except in the presence of infection of the uterine contents.

Threatened abortion characterized by the usual classical symptoms of pelvic distress, backache and bleeding of variable degree, is treated by complete bed rest, sedatives, and general supportive measures. If the condition progresses to a state where there is free hemorrhage, cervical dilatation and rupture of the membranes, which brings it into the category of the incomplete inevitable abortion, assistance is given as indicated by the particular case. Such a patient should be hospitalized and the cervix inspected to determine the presence of protruding placental fragments and retained clots. Pituitrin is most useful here to aid the uterus in throwing off its contents. If, however, there is free bleeding or prolonged hemorrhage of moderate or even small amounts, or severe distress with no immediate prospect of relief, we favor careful curettage under gas anesthesia to save loss of blood with its debilitating effects that favor sepsis and other complications.

Infected incomplete abortion should be treated with intelligent conservatism, characterized by complete bed rest, semi-Fowler's posture, fluids, adequate nourishment, sleep, ice bags or heat as preferred, relief of pain, general supportive measures, ergot. Curettage here is justified only in event of prolonged or excessive hemorrhage, but this does not preclude careful inspection of the cervix and the removal with a sponge forceps of tissue masses or clots that may be protruding into or from it. In event of pelvic abscesses developing, vaginal drainage through a posterior colpotomy opening may be necessitated later. Here one must avoid undue trauma with its attendant danger of spreading infection to the abdominal peritoneum. Gastro-intestinal symptoms must be dealt with on their own merit, such as gastric lavage, duodenal drainage, etc. Intravenous therapy is limited to transfusion of whole blood, saline or glucose solutions, which measures are often of the greatest benefit. Scarlet fever antitoxin may be used to great advantage in the presence of conditions such as hemolytic streptococcus infection with its marked toxicity, high temperature, rapid pulse, great fluid depletion, blood destruction, extensive cellular infiltration.

Our attitude toward abortion then is one of conservatism and watchful waiting, with the institution of interference as justified by intelligent observation. First, oxytocics to improve the tone of the uterus and aid its emptying in incomplete abortion and routinely after its cavity is emptied. Second, curettage in the noninfected retained abortion and in the incomplete abortion, whether infected or not, in the presence of prolonged or excessive bleeding. In case of doubt in this particular instance, we prefer to err on the side of radicalism. Third, general supportive and special measures as warranted in any particular problem.

Where interference is indicated, we favor curettage and the use of a blunt-nosed sponge forceps, but not the use of a cervical and vaginal pack. We have no hesitancy in using a medium type of curet, neither dull nor sharp, but we do try to avoid too vigorous scraping and excessive pelvic manipulation as well as too forceful and too extensive and, therefore, damaging dilatation of the cervix. For this latter reason we rarely, if ever, attempt to cleanse the uterine cavity with the gloved finger.

One cubic centimeter of pituitrin is administered routinely before curettement to give tone to the uterine musculature and thus render it less liable to perforation by the curet. We use the Starlinger uterine dilator followed by the Godell instrument, the force being controlled by the sense of touch, thus avoiding too forcible dilatation with extensive cervical damage. The uterine cavity is sponged routinely with an iodin pack immediately following curettage. Occasionally we resort to irrigation of the uterus with an antiseptic solution at 115 degrees. This evacuates shreds of tissue and clots and is an excellent aid in increasing uterine tone.

The presence of complicating pelvic pathology such as fibromata, diseased tubes, ovaries, etc., does not materially alter our immediate treatment of abortion as we prefer to follow the general plan outlined above, leaving these factors for later consideration whenever possible.

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PHILIP H. ARNOT, M. D. (490 Post Street, San Francisco).—There is no absolute rule that one can follow in treating an abortion case. However, a good working rule is to keep these patients flat in bed, give them a sedative such as codein, paregoric and viburnum, or morphin, and await developments. No one can tell whether the fetus is dead or alive, even in cases with moderate bleeding, so, I believe it is best to give the fetus the benefit of the doubt as long as there is no risk to the mother. In a rather large percentage of threatened abortions the bleeding will stop with bed rest and sedatives and the patient will go to term and have a perfectly normal child.

In most cases after the fetus dies the entire products of conception will pass spontaneously within a few days, and hence curettage will not be necessary. In a smaller percentage of cases there will be fever or hemorrhage or a dilated cervix with the products easily felt in the cervix or there will be a question if all of the products have been passed. What to do with these patients?

A patient who has bled or is bleeding enough to show signs of anemia should have the uterus evacuated as quickly as possible. If hemorrhage has been real severe a transfusion of blood will not only combat shock but will help build up the patient's resistance to infection.

Fever in the great majority of cases is due to a so-called putrid or saprophytic endometritis. This is not a true infection of the uterus, but is an infection of the dead and necrotic products of conception and decidua which are retained within the uterus. The infection of this material produces toxalbumoses and ptomains, which irritate the endometrium and excite a tissue reaction. The usual organisms are anaërobic streptococci and

Bacillus coli. The fever is usually high (101 to 104 degrees Fahrenheit), there is much perspiration, generalized aching and malaise and moderate tenderness of the uterus. Immediate evacuation of the uterus is indicated and is usually followed by a rapid drop in temperature, reaching normal in four to six hours.

In cases where the cervix is dilated and the products of conception can be felt and where there is no fever or hemorrhage, it is best to give pituitrin (one-half of a cubic centimeter every hour for four doses) and ergot with the hope of forcing the products out of the uterus. This will work in many cases, but if it has not at the end of twenty-four hours, the uterus should be evacuated.

In some cases, particularly around three to four months, a patient will pass just the fetus or only a small piece of the placenta so that one is sure that the uterus is not completely emptied. Unless fever or hemorrhage demands immediate evacuation it is best to try pituitrin and ergot for twenty-four hours before resorting to surgery.

There is always a question what to do in cases with a definite peritonitis or a septicemia. With peritonitis present I believe that the uterus should be left alone and all efforts bent toward treating the peritonitis—ice bags on the abdomen, intravenous glucose and subcutaneous saline, sedatives and the Connell suction apparatus in case of vomiting. However, severe hemborrhage would justify operative interference.

With septicemia present I feel that the uterus should be emptied only in case of hemorrhage or where the products can be felt within the open cervix or where one is sure that the uterus is not completely empty. Blood transfusions help, along with sedatives, fluids, and general supportive treatment. I have used intravenous mercurochrome in one case, but with no success.

As to the operation or method in emptying the uterus, I prefer to call it an evacuation of the uterus rather than a curettage, as I do not use nor advocate the use of a curet. One can use a sponge stick or a fenestrated forceps and completely clean out the uterine cavity. The uterine cavity is then swabbed with tincture of iodin and a plain gauze pack is inserted and removed in twelve to twenty-four hours. No intrauterine irrigation is advisable. The cervix seldom needs any dilatation, but where it is necessary the graduated dilators, such as Hegar's, are used to gently dilate the cervix.

Rarely one may have a parametrial, tubal, or cul-de-sac abscess, which should be opened and drained through a posterior colpotomy opening.

Ergot should be given in all postoperative cases for about three days, and in all septicemia and peritonitis cases.

Last but not least, do not forget the legal angles to this subject. Have consultation, if possible, on any patient that you have to operate or that is dangerously ill and be sure to report all such cases to your local police. This is for your own protection and should be done regardless of whether it is a spontaneous or an induced abortion.

New Regulations for the Practice of Medicine in Buenos Aires.—The national department of public health has presented a proposed law to the Secretary of National Affairs for the regulation of the practice of medicine. The project will be presented to the house of representatives. The following regulations are proposed: that the only persons authorized to practice medicine or any of its branches are those who have a national diploma or a foreign diploma duly legalized. Foreign physicians with a legal diploma may be authorized to practice in places where there are no legal national physicians, when they have a diploma given in a foreigh school, not as yet recognized in Argentina. In this case, however, if a legal national physician comes to that place, the right to practice belongs to the national and not to the foreign physician. Foreign physicians who want their diplomas legalized should take an examination of all subjects studied during the entire course of medicine, and then they must pay 4,000 pesos (about $1,040) for their licenses. The law would apply to the practice of medicine, dentistry and obstetrics and to roentgenologists, hypnotists and other psychotherapists. Any advertising by physicians and any other persons practicing has to be authorized by the national department of public health. It is considered illegal to specify the time it may require for any cure, to say that any cure is infallible, to use secret or mysterious remedies, and to publish false or inexact statistics compiled from methods used. No physician is allowed to practice pharmacy and medicine simultaneously. Physicians, dentists or veterinary physicians who in any way are engaged in the preparation or sale of specifics, either as owners or as stockholders, are not allowed to practice their professions. However, physicians are authorized to enter into association with capitalists to establish sanatoriums as long as the capitalist does not interfere in any clinical or technical work of the sanatorium. The sharing of fees by physicians, as well as the remuneration given to them from drug stores, opticians and orthopedists, and any other conventional arrangement for the mutual benefit of the physician with some other person or institution, is forbidden. The law considers it advisable that nurses, masseurs, dental mechanics, clinical laboratories, sanatoriums, maternity hospitals, medical and physical therapy clinics and eye clinics, should be under special regulations. This bill has been presented to congress for consideration. The laws that now govern the practice of medicine were made long ago and do not deal with certain problems of modern practice.—Buenos Aires *News Letter. (Journal of the American Medical Association.)*

Diagnosis and Management of Senile Prostate.—Young is convinced that in prostatectomy the perineal route is not only technically the most satisfactory but also the safest. It is accompanied by a mortality much less than can be obtained through the suprapubic route, whether the operation is done in one or two stages. The author presents an analysis of 197 consecutive cases of perineal prostatectomy without a fatality. This operation permits the surgeon to see the prostate, to examine minutely any region suspected of being malignant, to carry out operation under visual inspection, and to provide for complete hemostasis and good dependent drainage. These attributes make the perineal route unquestionably the method of choice, and are responsible for its greatly lower mortality.—*Southern Surgeon.*

Pathologic Changes in Tonsils.—Rhoads believes that in many cases simple inspection reveals sufficient evidence for the removal of tonsils. In most cases, however, it is of little importance as compared with the evidence adduced by a careful history, ordinary laboratory examinations, and a painstaking physical examination. Teamwork by the internist and the otolaryngologist is required. If the general examination reveals a systemic disease that is usually associated with focal infection, and other more obvious foci are not discovered, the tonsils should be regarded as probable sources of infection regardless of their external appearance.—*Archives of Otolaryngology.*